Appendix

The enclosed set of 12 short questionnaires will give most clinics a quick overview of the sleep issues of most patients. If you would like to have the scoring sheets for these scales, please contact us and we will be pleased to send them to you.

1. The Epworth Sleepiness Scale (ESS), a widely used measure of sleepiness
2. The Fatigue Severity Scale, a widely used measure of fatigue
3. The Toronto Hospital Alertness scale (THAT), an easy-to-use measure of alertness
4. Owl Lark Self-Test, helps assess body clock rhythm
5. Athens Insomnia Scale, to quickly assess features of insomnia
6. STOP BANG, easy-to-use inquiry regarding sleep apnea
7. The Restless legs questionnaire helps to detect Restless Legs syndrome and the
8. CAGE – a quick screening measure for alcohol dependence
9. CES-D, screen for mood-related problems which is common in patients with sleep disorders
10. Zung Anxiety scale
11. Illness intrusiveness scale
12. FACES adjective checklist

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Epworth Sleepiness Scale

Name: _____ Today's date: _____

Your age (Yrs): _____ Your sex (Male = M, Female = F): _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the **most appropriate number** for each situation:

0 = would **never** doze
1 = **slight chance** of dozing
2 = **moderate chance** of dozing
3 = **high chance** of dozing

It is important that you answer each question as best you can.

Situation	**Chance of Dozing (0-3)**
Sitting and reading _____	___
Watching TV _____	___
Sitting, inactive in a public place (e.g. a theatre or a meeting) _____	___
As a passenger in a car for an hour without a break _____	___
Lying down to rest in the afternoon when circumstances permit _____	___
Sitting and talking to someone _____	___
Sitting quietly after a lunch without alcohol _____	___
In a car, while stopped for a few minutes in the traffic _____	

THANK YOU FOR YOUR COOPERATION

FATIGUE SEVERITY SCALE

During the past week, I have found that:	Strongly Disagree			Neither Agree Nor Disagree			Strongly Agree
1. My motivation is lower when I am fatigued.	1	2	3	4	5	6	7
2. Exercise brings on my fatigue.	1	2	3	4	5	6	7
3. I am easily fatigued.	1	2	3	4	5	6	7
4. Fatigue interferes with my physical functioning.	1	2	3	4	5	6	7
5. Fatigue causes frequent problems for me.	1	2	3	4	5	6	7
6. My fatigue prevents sustained physical functioning.	1	2	3	4	5	6	7
7. Fatigue interferes with carrying out certain duties and responsibilities.	1	2	3	4	5	6	7
8. Fatigue is among my three most disabling symptoms.	1	2	3	4	5	6	7
8. Fatigue interferes with my work, family, or social life.	1	2	3	4	5	6	7

TORONTO HOSPITAL ALERTNESS TEST (THAT)

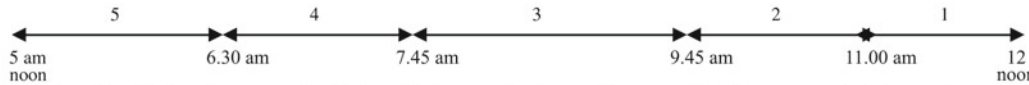
This questionnaire tries to establish how alert you feel. In reporting your feeling, we would like you to consider your last week. Use the following scale to check one response for each question.

During the last week I felt:	Not at all	Less than ¼ of the time	¼ to ½ of the time	½ to ¾ of the time	More than ¾ of the time	All the time I was awake
	0	1	2	3	4	5
1. Able to concentrate						
2. Alert						
3. Fresh						
4. Energetic						
5. Able to think of new ideas						
6. Vision was clear noting all details (e.g. driving)						
7. Able to focus on the task at hand						
8. Mental facilities were operating at peak level						
9. Extra effort was needed to maintain alertness						
10. In a boring situation, I would find my mind wandering						

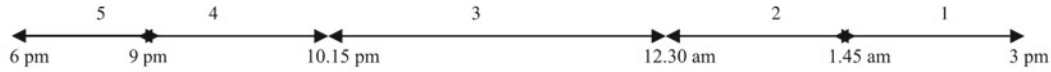
THE OWL LARK SELF-TEST

With these last 19 questions do your best. Select one answer that makes the most sense to you.

1. Considering only you own "feeling best" rhythm, at what time would you get up if you were entirely free to plan your day? (Choose time period by circling 5, 4, 3, 2 or 1)



2. Considering only you own "feeling best" rhythm, at what time would you go to bed if you were entirely free to plan your evening(Choose time period by circling 5, 4, 3, 2 or 1)



3. If there is a specific time at which you have to get up in the morning, to what extent are you dependent on being woken up by an alarm clock?
   - Not at all dependent ☐4
   - Slightly dependent ☐3
   - Fairly dependent ☐2
   - Very dependent ☐1

4. Assuming adequate environmental conditions, how easy do you find getting up in the morning?
   - Not at all easy ☐1
   - Not very easy ☐2
   - Fairly easy ☐3
   - Very easy ☐4

5. How alert do you feel during the first half hour after having woken in the mornings?
   - Not at all alert ☐1
   - Slightly alert ☐2
   - Fairly alert ☐3
   - Very alert ☐4

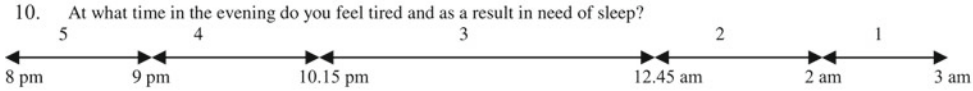
6. How is your appetite during the first half hour after having woken in the mornings?
   - Very poor ☐1
   - Fairly poor ☐2
   - Fairly good ☐3
   - Very good ☐4

7. During the first half hour after having woken in the morning, how tired do you feel?
   - Very tired ☐1
   - Fairly tired ☐2
   - Fairly refreshed ☐3
   - Very refreshed ☐4

8. When you have no commitments the next day, at what time do you go to bed compared to your usual bedtime?
   - Seldom or never later ☐4
   - Less than one hour later ☐3
   - 1-2 hours later ☐2
   - More than tow hours later ☐1

9. You have decided to engage in some physical exercise. A friend suggests that you do this one hour twice a week and the best time for him is between 7:00 – 8:00 am. Bearing in mind nothing else but you own "feeling best" rhythm, how do you think you would perform?
   - Would you be in good form ☐4
   - Would be in reasonable form ☐3
   - Would find it difficult ☐2
   - Would find it very difficult ☐1

10. At what time in the evening do you feel tired and as a result in need of sleep?



11. You wish to be at your peak performance for a test which you know is going to be mentally exhausting and lasting for two hours. You are entirely free to plan your day and considering only your own "feeling best" rhythm, which ONE of the four testing times would you choose?
   - 8:00 – 10:00 am ☐6
   - 11:00 am –1:00 pm ☐4
   - 3:00 pm – 5:00 pm ☐2
   - 7:00 – 9:00 pm ☐0

12. If you went to bed at 11:00 pm, at what level of tiredness would you be?
   - Not at all tired ☐0
   - A little tired ☐2
   - Fairly tired ☐3
   - Very tired

14. One night you have to remain awake between 4– 6:00 am in order to carry out a night watch. You have no commitments the next day. Which ONE of the following alternatives will suit you best?
   - Would NOT go to bed until watch was over ☐1
   - Would take a nap before and sleep after ☐2
   - Would take a good sleep before and nap after ☐3
   - Would take ALL sleep before watch ☐4

15. You have to do two hours of hard physical work. You are entirely free to plan your day and consider only your own "feeling best" rhythm, which ONE of the following times would you choose?
   - 8:00 am – 10:00 am ☐4
   - 11:00 am – 1:00 pm ☐3
   - 3:00 pm – 5:00 pm ☐2
   - 7:00 pm – 9:00 pm ☐1

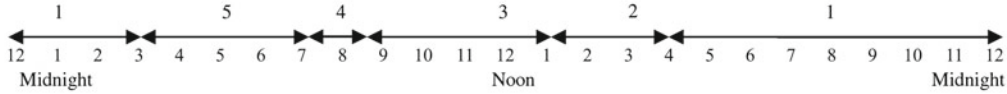
13. For some reason you have gone to bed several hours later than usual, but there is no need to get up at any particular time the next morning. Which ONE of the following events are you most likely to experience?

- ☐4 Will wake up at usual time and will NOT fall asleep again
- ☐3 Will wake up at usual time and will dose thereafter
- ☐2 Will wake up at usual time but will fall sleep again
- ☐1 Will NOT wake up until later than usual

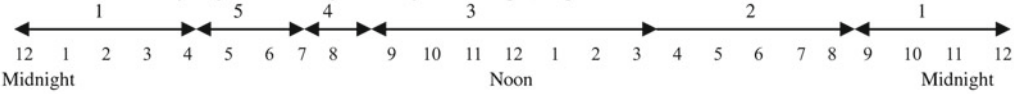
16. You have decided to engage in hard physical exercise. A friend suggests that you do this for one hour twice a week and the best time for him is between 10:00 – 11:00 pm. Bearing in mind nothing else but your own "feeling best" rhythm, how well do you think you would perform?

Would you be in good form	☐1
Would be in reasonable form	☐2
Would find it difficult	☐3
Would find it very difficult	☐4

17. Suppose that you can choose your own work hours. Assume that you worked a FIVE-hour day (with breaks) and that you job was interesting and paid by results. Which five consecutive hours would you select?



18. At what time of the day do you think that you reach your "feeling best" peak?



19. One hears about "morning" and "evening" types of people. Which ONE of these types do you consider your self to be?

Definitely a "morning" type?	☐6
Rather than a "morning" than an "evening" type	☐4
Rather more an "evening" than a "morning" type	☐2
Definitely an "evening" type	☐0

ATHENS INSOMNIA SCALE

This scale is intended to record your own assessment of any sleep difficulty you might have experienced. Please, check (by circling the appropriate number) the items below to indicate your estimate of any difficulty, provided that it occurred at least three times per week during the last month.

3. Sleep induction (time it takes you to fall asleep after turning-off the lights)

0: No problem 1: Slightly delayed 2: Markedly delayed 3: Very delayed or did not sleep at all

4. Awakenings during the night

0: No problem 1: Minor problem 2:Considerable problem 3: Serious problem or did not sleep at all

5. Final awakening earlier than desired

0: Not earlier 1: A little earlier 2: Markedly earlier 3: Much earlier or did not sleep at all

6. Total sleep duration

0: Sufficient 1:Slightly insufficient 2:Markedly insufficient 3: Very insufficient or did not sleep at all

7. Overall quality of sleep (no matter how long you slept)

0: Satisfactory 1:Slightly unsatisfactory 2: Markedly unsatisfactory 3: Very unsatisfactory or did not sleep at all

8. Sense of well-being during the day

0: Normal 1:Slightly decreased 2: Markedly decreased 3: Very decreased

9. Functioning (physical and mental) during the day

0: Normal 1:Slightly decreased 2: Markedly decreased 3: Very decreased

10. Sleepiness during the day

0: None 1: Mild 2: Considerable 3: Intense

STOP-BANG

STOP

Do you **S**nore?	Yes ❑	No ❑
Do you feel **T**ired, fatigued or sleepy during the day?	Yes ❑	No ❑
Has anyone **O**bserved you stop breathing in your sleep?	Yes ❑	No ❑
Do you have high blood **P**ressure ?	Yes ❑	No ❑

Please count the number of "Yes" responses and put the number in this box ❑

B	**A**	**N**	**G**
BMI	Age	Neck Size	Gender
>35	>50 y	> 40cm > 15.7"	- Male
See pg. B	F	B	F

If height is	4'10"	5'0"	5'2"	5'4"	5'6"	5'8"	5'10"	6'0"	6'2"	6'4"
& weight is >	167	179	191	204	216	230	250	258	272	287

Then BMI is > 35

RLS QUESTIONNAIRE

Please, answer the following questions according to your best knowledge! Where you can choose between **Yes** or **No,** circle the appropriate.

1. Does it happen or did it happen earlier that you experienced recurrent unpleasant sensation or tingling in your legs, while sitting or laying down? ..... **Yes / No**

   If **Yes,** how would you describe this sensation? (circle one):

   a. painful **b. unpleasant** **c. both painful and unpleasant**

2. Does it happen or did it happen earlier that you repeatedly felt an urge to move your legs while sitting or laying down?..... **Yes /No**
   If yes, do you need move your whole body not only your legs?.....**Yes / No**
   THIS FEELING, THAT YOU HAVE TO MOVE, IS SOMETIMES SO PRESSING THAT YOU CAN NOT RESIST IT… YES / NO
   OR YOU JUT SIMPLY HAVE TO MOVE YOUR ARMS OR LEGS?..... YES / NO

3. Do your legs jump or move a lot involuntarily while sitting or laying down?.....**Yes / No**

   If **yes**, do you think that the sensations in your legs and the movements are connected?.....**Yes/ No**

   If **yes**, how often do these involuntary movements occur (circle only one answer):

   seldom **occasionally** **frequently** **almost always**

   Do these involuntary movements occur only before you fall asleep?.....**Yes/ No**

4. Do you feel, or did you feel earlier that there are recurrent periods when you are so *itchy, you can not stay in one place* or you have to move your arms or legs?..... **Yes /No**

Continue to answer the following questions **only** if you answered **yes** to at least one of the previous questions. If you answered **no** to all of the above questions, please go to the next page**.**

5. When these sensations or movements occur, are they worse while you have a rest (while sitting or laying down) than during physical activities?..... **Yes / No**

6. If these sensations or movements are present and you get up walking, are they improving or do they disappear while you are walking? Please, try to remember, that you may have observed that these sensations or movements are getting worse again when you stop walking, but they are less cumbersome while you are walking?.....**Yes/ No / Don't Know**

Continue to answer the following questions only if you answered **yes** to both of the last two questions. If you answered no to question 5 or 6, please go to the next page.

7. If these sensations or movements are present are they gettng worse in the evening or during the night?.**Yes / No**

8. Not NOW, but when these sensations or movements have started, and perhaps they were not as bad as they are now, were these sensations or movements getting worse in the evening or during the night?.....……**Yes/ No**

CAGE

It is an instrument used to screen for alcoholism.

Two 'yes' response indicates that the client should be investigated further.

1 Have you ever felt you needed to **Cut** down on your drinking?

2 Have people **Annoyed** you by criticizing your drinking ?

3 Have you ever felt **Guilty** about drinking ?

4 Have you ever felt you needed a drink first thing in the morning (**E**ye –opener) to steady your nerves or to get rid of a hangover?

CENTER FOR EPIDEMIOLOGIC STUDIES DEPRESSION (20)

Below is a list of the ways you might have felt or behaved. Please indicate how often you have felt this way DURING THE PAST WEEK.

0 = Rarely or None of the Time (Less than l Day)
1 = Some or a Little of the Time (1 - 2 Days)
2 = Occasionally or a Moderate Amount of Time (3 - 4 Days)
3 = Most or All of the Time (5 - 7 Days)

	DURING THE PAST WEEK:	Rarely/ None	Some/ A Little	Occasionally/ Moderately	Most/ All
1.	I was bothered by things that usually don't bother me	0	1	2	3
2.	I did not feel like eating; my appetite was poor.	0	1	2	3
3.	I felt that I could not shake off the blues even with help from my family or friends.	0	1	2	3
4.	I felt that I was just as good as other people	0	1	2	3
5.	I had trouble keeping my mind on what I was doing.	0	1	2	3
6.	I felt depressed.	0	1	2	3
1.	I felt that everything I did was an effort.	0	1	2	3
2.	I felt hopeful about the future.	0	1	2	3
3.	I thought my life had been a failure.	0	1	2	3
4.	I felt fearful.	0	1	2	3
5.	My sleep was restless.	0	1	2	3
6.	I was happy.	0	1	2	3
13.	I talked less than usual.	0	1	2	3
14.	I felt lonely.	0	1	2	3
15.	People were unfriendly.	0	1	2	3
16.	I enjoyed life	0	1	2	3
17.	I had crying spells.	0	1	2	3
18.	I felt sad.	0	1	2	3
19.	I felt that people disliked me.	0	1	2	3
20.	I could not get "going".	0	1	2	3

ZUNG ANXIETY

HOW OFTEN HAS EACH OF THE FOLLOWING STATEMENTS APPLIED TO YOU DURING THE PAST 2 WEEKS.

1 = NONE OR A LITTLE OF THE TIME 3 = GOOD PART OF THE TIME

2 = SOME OF THE TIME 4 = MOST, OR ALL, OF THE TIME

		NONE			MOST
1.	I feel more nervous and anxious than usual	1	2	3	4
2.	I feel afraid for no reason at all	1	2	3	4
3.	I get upset easily or feel panicky	1	2	3	4
4.	I feel like I'm falling apart and going to pieces	1	2	3	4
5.	I feel that everything is all right and nothing bad will happen	1	2	3	4
6.	My arms and legs shake and tremble	1	2	3	4
7.	I am bothered by headaches, neck and back pains	1	2	3	4
8.	I feel weak and get tired easily	1	2	3	4
9.	I feel calm and can sit still easily	1	2	3	4
10.	I can feel my heart beating fast	1	2	3	4
11.	I am bothered by dizzy spells	1	2	3	4
12.	I have fainting spells or feel like fainting	1	2	3	4
13.	I can breathe in and out easily	1	2	3	4
14.	I get feelings of numbness and tingling in my fingers and toes	1	2	3	4
15.	I am bothered by stomach aches or indigestion	1	2	3	4
16.	I have to empty my bladder often	1	2	3	4
17.	My hands are usually dry and warm	1	2	3	4
18.	My face gets hot and blushes	1	2	3	4
19.	I fall asleep easily and get a good night's rest	1	2	3	4
20.	I have nightmares	1	2	3	4

ILLNESS INTRUSIVENESS RATING SCALE

Please circle the one number that best describes your current life situation. If an item is not applicable, please circle the number (1) to indicate that this aspect of your life is not affected very much. Please do not leave any items unanswered.

HOW MUCH DOES YOUR SLEEP PROBLEM AND/OR ITS TREATMENT INTERFERE WITH YOUR:

		Not very much						Very much
1.	Health	1	2	3	4	5	6	7
2.	Diet	1	2	3	4	5	6	7
3.	Work	1	2	3	4	5	6	7
4.	Active Recreation (e.g., sports)	1	2	3	4	5	6	7
5.	Passive Recreation (e.g., reading, listening to music)	1	2	3	4	5	6	7
6.	Financial Situation	1	2	3	4	5	6	7
7.	Relationship With Your Partner	1	2	3	4	5	6	7
8.	Sex Life	1	2	3	4	5	6	7
9.	Family Relations	1	2	3	4	5	6	7
10.	Other Social Relations	1	2	3	4	5	6	7
11.	Self-Expression/Self-Improvement	1	2	3	4	5	6	7
12.	Religious Expression	1	2	3	4	5	6	7
13.	Community and Civic Involvement	1	2	3	4	5	6	7

FACES ADJECTIVE CHECKLIST

Below is a list of words that describe feelings people have. Please read each one carefully. Then circle the ONE number corresponding to the adjective phrase that best describes **HOW YOU HAVE BEEN FEELING DURING THE PAST WEEK INCLUDING TODAY**. If you are unfamiliar with any of the words, please circle the question mark (?) to the right of the rating scale. The numbers refer to the following descriptive phrases:

1.	Fatigued	0	1	2	3	4	?	26.	Comatose	0	1	2	3	4	?
2.	Worn-out	0	1	2	3	4	?	27.	Unconscious	0	1	2	3	4	?
3.	Exhausted	0	1	2	3	4	?	28.	Dormant	0	1	2	3	4	?
4.	Wacked-out	0	1	2	3	4	?	29.	Bombed	0	1	2	3	4	?
5.	Drained	0	1	2	3	4	?	30.	Blurry-eyed	0	1	2	3	4	?
6.	Pooped	0	1	2	3	4	?	31.	Vigorous	0	1	2	3	4	?
7.	Overtired	0	1	2	3	4	?	32.	Full of pep	0	1	2	3	4	?
8.	Weary	0	1	2	3	4	?	33.	Lively	0	1	2	3	4	?
9.	Tired	0	1	2	3	4	?	34.	Charged-up	0	1	2	3	4	?
10.	Spent	0	1	2	3	4	?	35.	Wide-eyed	0	1	2	3	4	?
11.	Bushed	0	1	2	3	4	?	36.	Energetic	0	1	2	3	4	?
12.	Out of Steam	0	1	2	3	4	?	37.	Carefree	0	1	2	3	4	?
13.	Frazzled	0	1	2	3	4	?	38.	Active	0	1	2	3	4	?
14.	Limited Endurance	0	1	2	3	4	?	39.	Cheerful	0	1	2	3	4	?
15.	Achy Muscles	0	1	2	3	4	?	40.	Alert	0	1	2	3	4	?
16.	Indolent	0	1	2	3	4	?	41.	Snoozy	0	1	2	3	4	?
17.	Languid	0	1	2	3	4	?	42.	Sleepy	0	1	2	3	4	?
18.	Soporific	0	1	2	3	4	?	43.	Drowsy	0	1	2	3	4	?
19.	Lassitude	0	1	2	3	4	?	44.	Slumber	0	1	2	3	4	?
20.	Supine	0	1	2	3	4	?	45.	Heavy-eyed	0	1	2	3	4	?
21.	Accidie	0	1	2	3	4	?	46.	Half-Awake	0	1	2	3	4	?
22.	Phlegmatic	0	1	2	3	4	?	47.	Sluggish	0	1	2	3	4	?
23.	Line of Least Resistance	0	1	2	3	4	?	48.	Yawning	0	1	2	3	4	?
24.	Jaded	0	1	2	3	4	?	49.	Dozy	0	1	2	3	4	?
25.	Apathetic	0	1	2	3	4	?	50.	Somnambulant	0	1	2	3	4	?

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